TEXAS DEPARTMENT OF HEALTH
RETAIL FOODS DIVISION

BUDGET 7B708
FUND: 126

LICENSE #:

CERTIFIED FOOD MANAGEMENT PROGRAM
CANDIDATE REPLACEMENT CERTIFICATE FORM

Return both the completed application and fee made payable to the
TEXAS DEPARTMENT OF HEALTH in the envelope provided or mail to:
Texas Department of Health, P. O. Box 149200, Austin, Texas 78714-9200.
You may visit our website at: www.tdh.state.tx.us/bfds

This form **MUST** be completed and returned along with a check or money order for the **non-refundable** fee of **$10.00** to the Texas Department of Health. A new certificate card will be sent to the address listed below.

PLEASE TYPE OR PRINT LEGIBLY:

Name: _____
Last First MI

Social Security #: _____

Mailing Address: _____
Street City State Zip

Telephone Home: _____ Business: _____
Area Code Number Area Code Number

CERTIFIED FOOD MANAGEMENT PROGRAM OR TEST SITE ATTENDED:

CFM Program or Test Site Name: _____

Date of Training or Examination: _____

Location: _____
Street City State Zip

VERIFICATION: I SWEAR OR AFFIRM THAT ALL INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature Date

_____
Printed Name & Title

Revised 06/12/02